No. 06-

IN THE

Supreme Court of the United States

RONALD A. McIVER, D.O.,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

May a physician who treats chronic pain patients be convicted of intending to traffick in drugs for merely failing to conform with a "professional norm" that is "within" but not "outside" the "course of professional medical practice" as required by this Court's holding in *United States v. Moore*, 423 U.S. 122, 143, 96 S.Ct. 335 (1975)?

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Petitioner Ronald A. McIver, D.O., respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit in this case.

OPINION BELOW

The opinion of the Fourth Circuit Court of Appeals (Pet. App. 1a-31a) is reported at 470 F.3d 550 (2006).

STATEMENT OF JURISDICTION

The court of appeals entered its judgment on December 5, 2006. The court of appeals denied petitioners' petition for rehearing by order dated January 3, 2007 (Pet. App. 40a-41a). The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

STATUTORY PROVISIONS AND REGULATIONS INVOLVED

a. Pertinent regulation:

21 C.F.R. §1306.04 provides:

§ 1306.04 Purpose of issue of prescription

> (a) A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a

prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a purported prescription, as well as the person using it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.

(b) A prescription may not be issued in order for an individual practitioner to obtain controlled substances for supplying the individual practitioner for the purpose of general dispensing to patients.

(c) A prescription may not be issued for "detoxification treatment" or "maintenance treatment," unless the prescription is for a Schedule III, IV, or V narcotic drug approved by the Food and Drug Administration specifically for use in maintenance or detoxification treatment and the practitioner is in compliance with requirements in § 1301.28 of this chapter.

b. Pertinent portions of the Controlled Substances Act:

21 U.S.C. §841(a) provides:

§ 841. Prohibited Acts A

(a) Unlawful acts

Except as authorized by this subchapter, it shall be unlawful for any person knowingly or intentionally —

(1) to manufacture, distribute, or dispense, or possess with intent to

manufacture, distribute, or dispense, a controlled substance; or

(2) to create, distribute, or dispense, or possess with intent to distribute or dispense, a counterfeit substance.

21 U.S.C. §802(5) and (21) provide:

§ 802. Definitions

As used in this subchapter:

*****

(5) The term 'control' means to add a drug or other substance, or immediate precursor, to a schedule under part B of this subchapter, whether by transfer from another schedule or otherwise.

*****

(21) The term 'practitioner' means a physician, dentist, veterinarian, scientific investigator, pharmacy, hospital, or other person licensed, registered, or otherwise permitted by the United States or the jurisdiction in which he practices or does research, to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.

21 U.S.C. §821 provides:

§ 821. Rules and regulations

> The Attorney General is authorized to promulgate rules and regulations and to charge reasonable fees relating to the registration and control of the manufacture, distribution, and dispensing of controlled substances and to the registration and control of regulated persons and of regulated transactions.

STATEMENT OF THE CASE

A. Jurisdiction

This petition arises out of the criminal prosecution of a physician, Dr. Ronald McIver, the petitioner herein, who treated chronic pain patients in the District of South Carolina. The charges were based on Title 21, United States Code, Section 841 and the district court had jurisdiction pursuant to 18 U.S.C. §3231.

B. The charges, conviction and appeal

Dr. McIver treated 1,000 patients in his medical practice. Dr. McIver was targeted based on his prescription of opioids to these patients. The government culled from his seized medical files 10 chronic pain patients that they considered to be inappropriately treated. The jury convicted Dr. McIver as to 6 of those 10 patients. Several patients stated at trial that they had "conned" Dr. McIver about whether they needed pain medication. The government's expert also described "norms" that he thought should apply that were within the bounds of professional medical practice. In the end, this prosecution was therefore about how Dr. McIver treated less than 1% of all of his pain patients, according to the "norms" defined at trial by the government's expert.

Dr. McIver was indicted on one count of conspiring with individual pain patients to unlawfully distribute controlled substances, despite the fact that the underlying distribution charge itself required the concerted action of at least two persons.

Dr. McIver was also charged with fourteen counts of unlawful distribution of controlled substances, based on the prescriptions he wrote for pain medication for ten chronic pain patients at his pain management clinic.

The prosecution was not about whether Dr. McIver intended to traffic in drugs, instead of treating his patients; it was not about whether Dr. McIver had acted "outside the course of professional medical practice"; it was not about whether Dr. McIver intended to act as a "pusher"; the prosecution was instead about whether Dr. McIver violated "professional norms" defined for the first time by the government's expert at trial and entirely "within" the course of professional medical practice.

The jury trial lasted seven days, with five days of evidence (April 11-15, 2005), closing argument and jury instructions on April 18, 2005, and the adverse verdict received on April 19, 2005. The jury found Dr. McIver guilty of the conspiracy count and eight distribution counts involving the 6 patients. The jury acquitted on six distribution counts. On August 26, 2005, the district court imposed concurrent sentences of 30 years on counts 11 and 12, as to the patient Dr. McIver treated who died, and 20 years on each other count for distributing drugs, rather than treating patients. When remanded to custody, Dr. McIver had a heart attack and he is now lodged at the federal facility located in Butner, North Carolina.

On September 21, 2006, a 3-judge panel of the Court of Appeals for the 4th Circuit heard oral argument.

On December 5, 2006, the Circuit issued its opinion, and, on January 7, 2007, denied Dr. McIver's petition for *rehearing en banc*.

C. Pain in America – and how our Executive Branch makes it worse

Our Executive Branch is exceeding the authority granted by the U.S. Congress under Title 21, United States Code, Section 841(a)(1), that empowered the Executive Branch to prosecute physicians for illicit drug dealing when the physicians acted with the specific intent to push drugs rather than to treat patients. *United States v. Moore*, 423 U.S. 122, 143, 96 S. Ct. 335 (1975); *see also* Title 21, United States Code, Section 802(21).

Our Executive Branch is now prosecuting physicians for prescribing opioids to chronic pain patients because our Executive Branch disapproves of medical treatment with opioids and not because the physician is pushing drugs.

Our Executive Branch is prosecuting physicians for failing to conform with a "professional norm" that the Executive Branch defines for the first time at trial after the physician has treated the pain patient.

Petitioner was prosecuted because he didn't do what the "average" physician might do, and because he didn't conform to "the norm", as defined by the Executive Branch's expert, rather than because Dr. McIver acted "outside the course of professional medical practice" and with the specific intent to push drugs.

The Executive Branch's "norm" is less rigorous than the standard enunciated by the Congress, and the formulation approved by this Court in *Moore*, *supra*, in that the "norm" is any medical practice that deviates from an *ad hoc* "norm" that falls "within" and not "outside" the course of professional practice.

Our Executive Branch has thus usurped the authority reserved to the several states to regulate and to define appropriate medical treatment. *Compare* State Board of Medical Examiners of South Carolina: "Guidelines for the Use of Controlled Substances for the Treatment of Pain" (1999).

Our Executive Branch is supplanting its "judgment" for medical science and without the authority to create such "norms." This Court is well aware of how the Executive Branch exceeded its jurisdictional competence when it sought to defeat a state legislature's preference to allow assisted suicide. *Gonzales v. Oregon*, 546 U.S. 243, 126 S. Ct. 904, at 922 (2006).

This prosecution of a physician for failing to conform with a norm established by the Executive Branch is another instance of the Executive Branch exceeding its jurisdictional competence.

The Executive Branch, by its prosecutions, and the Fourth Circuit, by upholding the conviction below, eliminated the requisite specific intent that this court required in *Moore*.

The Executive Branch, and the lower courts, effectively created a strict liability standard for Section 841(a) when the Accused was a physician. The clearest indication that strict liability - and not specific intent – was the standard applied here was that, notwithstanding irrefutable evidence

that the pain patients "conned" the petitioning physician into prescribing medicine, Dr. McIver was found criminally responsible. The Fourth Circuit Court held in *United States v. Tran Trong Cuong*, 18 F.3d 1132 (4th Cir. 1994), that proof of negligent medical practice was hardly proof of any crime, particularly drug dealing. In *Tran*, the Fourth Circuit Court also held, if a patient "conned" a physician who gave drugs to the conniving patient, the physician lacked the knowledge and the specific intent to commit the crime of distribution.

This case therefore reflects an inapt retreat from specific intent to strict liability, and from "outside the course of professional practice" to an alleged deviation from some less rigorous "norm" as a standard to convict a physician.

This is a retreat from what was constitutionally permissible to what is constitutionally impermissible according to this Court's holding in *Moore*.

Our Executive Branch, by its wrong-headed prosecutions of physicians, is daily making chronic pain worse, creating a public health hazard, chilling the treatment by physicians of the millions of this nation's chronic pain patients when it should instead be easing the relentless pain that these chronic pain patients suffer.

D. Executive Branch Expert defines junk science "norm" at trial.

Dr. Storick, the government's expert, was addiction averse, like the government's policy, and too afraid of a patient's potential for addiction to treat chronic pain, even though only a small percentage of pain patients become addicted. J.A. 640.

Dr. Storick is afraid of being sued for prescribing OxyContin, J.A. 609, admits of a widespread fear ". . . that

the government will come after [physicians]," J.A. 583, and he minimizes how much OxyContin he prescribes, J.A. 608.

DEA Agent Rene Crowley conceded that neither Title 21, United States Code, Section 841, nor the Code of Federal Regulations, limited the number of OxyContin tablets that a physician may prescribe. J.A. 50. Ms. Crowley also conceded that there is no maximum dosage for any of the medications that were at issue in Dr. McIver's indictment, J.A. 51.

Dr. Storick admitted as well that there was no maximum dosage for opioids. J.A. 575. But this is where the problem arises as to "norms". Dr. Storick's norm is that the dosage should be limited. He acknowledged a University of Wisconsin Pain Management Study, at p. 60, that "[o]pioids should be titrated [increased] by a percentage of the current dose based on the intensity of pain." J.A. 584. Dr. Storick agreed that "titration" (increasing the dosage) was an apt approach for cancer patients, but he insisted it was "a controversial argument" as to other patients. J.A. 585. It was not outside the course of professional medical practice, he said, but it was "controversial." He dismissed the Wisconsin study as "academic" and insisted that he knew better because, he said, "I work for a living." J.A. 585. He grudgingly admitted some practicing physicians will titrate at a hundred percent for moderate to severe pain. J.A. 665. But he disagreed with that. J.A. 665.

Dr. Storick said that the highest daily dose that he would prescribe to a non-cancer patient with chronic pain was 160 mg OxyContin (80 mg OxyContin twice a day). J.A. 635-636. He said he was unfamiliar with the fact that Medicaid allows a daily dose of up to 960 mg of OxyContin (or eighty tablets). J.A. 638.

Dr. Storick also objected to any physician allowing any patient to take a range of dosages as necessary for pain, for example, one to five tablets. J.A. 643. He said that such a prescription wasn't "beyond the bounds of medical practice", just that it was "a lot of medicine." *Id.*

While other physicians might try to reduce a patient's pain from ten, being excruciating and unbearable pain, to three or two if possible, Dr. Storick would never try to reduce a patient's pain to less than 5 out of 10. J.A. 588. If you have a patient who says his pain is 4, according to Dr. Storick, the patient has to learn to live with it. J.A. 589, 590.

Dr. Storick insisted that 1 in 5 chronic pain patients are abusing medication sometime or other, unbeknownst to the physician. J.A. 505. But Dr. Mark Sullivan, Professor of Psychiatry and an Adjunct Professor of Medical History and Ethics at the University of Washington, confirmed, that only 2% of chronic pain patients may become addicted and that there is a 98% chance that a patient who claims that he has chronic pain is "on the level." *See* Pain, Opioids and Addiction: "An Urgent Problem for Doctors and Patients", 3/5/07, NIH Conference (*http://videocast.nih.gov/PastEvents.asp?c=1.*)

Knowing who is deceiving the physician is hard to uncover, according to a recent study conducted by Drs. Beth Jung and Marcus Reidenberg:

> Physicians operate with what *Burgoon et al.* call a *truth bias*. That is, they presume that patients' presentation of themselves are true, complete and accurate. Their assessment of patients' pain complaints are based both on current information (obtained in the interview and

> physical examination) and on the starting point, or anchoring point for the assessment. Doctors assume that patients come to see them because they have a problem for which they want treatment. Law enforcement personnel appear to have a different assumption when they interview some people.

See Jung G, Reidentbert M, DECEIVING PHYSICIANS, In Press (2006).

It is good that patients are "on the level," according to Dr. Sullivan, because there is almost no way to confirm that a person has pain; the Center for Disease Control statistics reveal that "80% of lower back pain cannot be identified with imaging" whether it's an fMRI, PET, CT-scan or x-ray. *See* Pain, Opioids and Addiction: "An Urgent Problem for Doctors and Patients", *supra*.

The medical community is of one mind that "[i]t is sometimes a difficult medical judgment as to whether opioid therapy is indicated in patients complaining of pain because objective signs are not always present." *See* "Rights and Responsibilities of Physicians in the Use of Opioids for the Treatment of Pain" (Public Policy Statement on the Rights and Responsibilities of Healthcare professionals in the use of Opioids for the Treatment of Pain – a consensus document of - the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine).

While cancer "is a symptom of a disease bearing a direct relationship predominantly with tissue pathology[,] ... there is only a *weak association* between reported pain and objective findings of disease in chronic pain not associated

with cancer" (italics supplied). *See* Loeser, BONICA'S MANAGEMENT OF PAIN, 3rd ed., Lippincott Williams & Wilkins (2001).

Dr. Storick confirmed on cross-examination that "pain is a subjective amount of discomfort" and "there's no way to really measure it." Dr. Storick, the government's expert, said he wouldn't prescribe opioids for any patient *unless* he could find objective signs of pain. J.A. 568. In other words, Dr. Storick would purposefully fail to treat patients with lower back pain, migraine headaches, fibromyalgia, reflexive sympathetic dystrophy disorder (RSD), and various neuropathic disorders — if he couldn't find "objective signs of pain". That was his norm or standard. But all of these disorders were treated by Dr. McIver.

E. The court's erroneous instructions

The court compounded the junk science that the government's expert published with its erroneous jury instructions:

(1) failing to instruct the jury in words or substance that Dr. McIver had "to intend" to push drugs,

(2) failing to instruct the jurors that acting "outside the course of professional medical practice" only "tended" to show drug dealing, and

(3) by giving the jury license to determine whether Dr. McIver deviated from "norms" that were not themselves "outside the course of medical practice", and inviting the jury to make up its own standard, instructing the jury that "there [were] *no specific guidelines* concerning what is required to support a conclusion that a defendant physician acted outside the usual course of professional practice .. ." (underscoring supplied). J.A. 1241, 1291.

The Court instructed: "A physician's own methods do not themselves establish what constitutes medical practice" and "in determining . . . whether the defendant's conduct was *within* the bounds of professional medical practice you should . . . consider the testimony you have heard relating to what has been characterized during the trial as *the norms of professional practice*" (underscoring supplied) J.A. 1243, 1293. The Court never instructed the jury how to reconcile an instruction regarding what was "*outside* the bounds of professional medical practice" with the less rigorous standard of what wasn't "normal" or "average."

The Court further instructed the jury: "You should also consider the extent to which, if at all, *any violation of professional norms* you find to have been committed interfered with his treatment of his patients and *contributed* to *an over prescription and/or excessive dispensation of controlled substances*" (emphasis supplied). J.A. 1243, 1293.

This particular instruction perhaps created the most mischief as it combined Dr. Storick's "norm" that there was a limit on prescribing opioids, that the patient could not decide for himself to dispense medication based on his pain, that prescribing opioids for some illnesses was "controversial", and that he would never prescribe an opiod absent an objective basis to confirm the origin of the pain. None of Dr. Storick's "norms" were "outside the bounds of professional medical practice." But the record shows these norms were conclusive of the counts for which Dr. McIver was convicted.

The court further instructed the jury to consider "the totality of [Dr. McIver's] actions and the circumstances surrounding them and the extent and the *severity of any violations of professional norms* you find he committed"

(emphasis supplied). J.A. 1244, 1294. But how was the jury to determine the "severity" of any "norm" except according to what the expert instructed.

F. The evidence at trial that was the subject of the expert's "junk science" and the court's erroneous jury instructions

We now discuss those patients that resulted in Dr. McIver's conviction, emphasizing the conjunction of the government's "norms" with the erroneous jury instructions; each conviction can be explained in this fashion:

1. Beverly Brown

Dr. Storick explained that "it was not beyond the scope of medical practice, [nor] out of the bounds of medical practice ... to prescribe an opioid for someone who's been a crack addict." J.A. 629. *See Linder v. United States*, 268 U.S. (1925).

But he wouldn't do it. J.A. 630. It wasn't his norm. He would use a "better drug." J.A. 630. Dr. Storick was asked, "Are there other physicians, Dr. McIver [for instance], somebody who may choose to [prescribe an opioid]? He said, "Sure. I'll disagree with that, but there's nothing wrong." J.A. 630.

That's what Dr. Storick said until, seemingly, he recalled that Beverly Brown (named in Count 5) was a crack addict. J.A. 630. Dr. Storick promptly reversed his position, and said it wasn't okay. J.A. 631. He said "some physicians probably would . . .", but he "can't tell you who," nor what percentage of medical practice does, *Id.*, only that this practice was "controversial" and not the norm. *Id.*

Ms. Brown also suffered from Reflex Sympathetic Dystrophy Disorder (RSD); Dr. Storick said that treating a patient with RSD with opioids was "very controversial." J.A. 522. It wasn't "outside the bounds of professional medical practice". But he wouldn't do it.

2. Kyle Barnes.

Kyle Barnes said he went to Dr. McIver because he had been diagnosed with fibromyalgia and understood that Dr. McIver treated the condition. J.A. 347-348. Dr. Storick thought treating fibromyalgia with opioids was "very controversial" except in low dosages because, otherwise, he feared the patient was diverting the medication. J.A. 511, 533-534. He confirmed that "medicine's a very gray area and fibromyalgia is a good example of a gray area." J.A. 661. He confirmed there's a difference of opinion in the medical profession about how best to treat fibromyalgia. J.A. 662. He said only a minority would treat fibromyalgia with opioids. J.A. 663. He said: "that's not a standard treatment for that patient." Id. Not the norm!

Mr. Barnes learned about Dr. McIver from the Internet, that he treated fibromyalgia, and he said: "I thank God every day for leading us to you." J.A. 367. He told Dr. McIver he was disabled from depression. J.A. 367. Dr. McIver conducted range of motion tests, directed exercises, sought relief from pressure points, massaged the muscles, confirmed that Mr. Barnes had fibromyalgia, and prescribed OxyContin. J.A. 350, 367-368. Mr. Barnes saw Dr. McIver for treatments for about two years. J.A. 351. Mr. Barnes' Medicaid did not cover the cost of his medicine and, unbeknownst to Dr. McIver, he sold some to make up the difference in cost. J.A. 330. He did the same with the methadone that Dr. McIver late prescribed. J.A. 354. At trial, Mr. Barnes said he had

exaggerated his pain. J.A. 361. He said he lied about the pain he had because he "didn't want to stop getting what [he] was getting. J.A. 363. Mr. Barnes first "confessed" that he had lied about his pain after he was charged with medicaid fraud — when he was testifying for the government. J.A. 358, 365.

3. Angela Knight

Angela Knight was Dr. McIver's patient for three years and until Dr. McIver was arrested. J.A. 387, 393. Ms. Knight, 61, had been in two car wrecks and suffered from a lower back pain injury from the '80s, suffered a compression fracture, perhaps aggravated by osteoporosis, and the pain was chronic, interfering with her ability to sleep and to work, and it was "worse some days than other days," forcing her to stay home on the worst days. J.A. 388, 398, 399, 534-535. Dr. McIver administered therapy, used electrodes, and prescribed medication including OxyContin. J.A. 388, 392. When she first visited Dr. McIver, her pain was 7 out of 10, and Dr. McIver's got it down to 3 or 4. J.A. 404. Over time she was able to walk as far as 2 ½ miles. J.A. 653. She had pain when she went to Dr. McIver and she still had the lower back pain and headaches when she testified at the trial. J.A. 397. She insisted that she took the OxyContin as prescribed and didn't abuse it. J.A. 407. While she had a negative drug screen (indicating she wasn't taking the OxyContin), she had a witness that she had taken the medicine, and Dr. McIver confirmed that the lab test wouldn't show OxyContin. J.A. 407, 994. While Dr. Storick thought that treating her for pain was "not an unreasonable treatment option," J.A. 541, he was concerned because she traveled from Lancaster to Dr. McIver, rather than use a physician closer to where she lived. J.A. 541-542. The most he could say was "that's sort of an unusual distance." J.A. 646.

Dr. Storick was also concerned that she a negative drug screen. J.A. 658. Dr. McIver was convicted of prescribing to her.

4. Les Smith

Les Smith claimed that the scar on one wrist from an accident, and the arthritis in his other wrist, accounted for his pain, necessitating pain medication. McIver found he had a syringe on one occasion, but he claimed he used it for "juicing up" the bait. J.A. 185, 980. Mr. Smith said at trial he had been lying to the physician. J.A. 179, 188, 195.

5. Seth Boyer

Seth Boyer had suture marks in his foot and claimed he had chronic pain. J.A. 254. Dr. McIver did in fact call and write the authorities asking whether his suspicions about some patients were well-founded, and whether he should discharge them as patients. J.A. 83-84, 981. But the government remained silent. J.A. 85-86. Boyer had track marks but he didn't think that Dr. McIver could see them. J.A. 254. He said at trial he was lying to Dr. McIver. J.A. 249, 254-256.

The government charged that Dr. McIver conspired with his patients. But, there is and can be no conspiracy, as a matter of law, when the offense requires concerted action to begin with, for instance, bribery (requiring two persons), or, as in this case, the distribution of a prescription drug (by a doctor to a patient); yet the jury was instructed that two persons who made a criminal agreement were sufficient to make out conspiracy. In addition, the patients he conspired with, Mr. Boyer and Mr. Smith, testified they tried to mislead Dr. McIver and "pretended not to know each other." J.A. 183.

6. Lawrence Shealy.

The patient who died, Lawrence Shealy, suffered relentless chronic pain from crippling arthritis, back and knee pain, heart disease, terrible depression, sleeplessness, and, unsurprisingly, had tried to commit suicide; there were even some x-rays of Mr. Shealy's back which showed "some degenerative changes or arthritic changes in his low back." J.A. 524.

Dr. Storick's testimony relating to Mr. Shealy was limited to the prescriptions he had, no medical records, no physical exams, no progress notes, not from Dr. McIver's practice, nor from Mr. Shealy's other physician, Dr. Mitchell. J.A. 525. But Storick said the prescriptions were for "a lot of medicine." J.A. 526. The mischief here is accomplished by Dr. Storick's summary comment, "a lot of medicine," in conjunction with the judge's charge, inviting the jury to consider "any violation of *professional norms* you find to have been committed . . . and [that] *contributed to an over prescription* and/or excessive dispensation of controlled substances" (underscoring added). J.A. 1243, 1293.

At the time of his death, on May 29, 2002, Mr. Shealy had an enlarged heart, a chronic problem that he'd had for years, an enlarged spleen and liver from congestive heart failure, severe coronary artery atherosclerosis, hardening of the arteries, 90% blockage of his left anterior descending artery, and a 50% blockage of the left circumflex arterial branch, a scarred heart from an earlier heart attacks, and congested organs, meaning, as the blood backs up into the system, that it backs into the organs. J.A. 422, 427, 431, 435.

There is every reason to believe that Mr. Shealy died because of the complications involving his heart disease, having nothing to do with the medication that he was taking:

> When defense attorneys raised the concept of sudden cardiac death, medical examiners [as here] typically resisted this possibility. One testified that the decedent wasn't known to suffer from cardiac disease. This contention reveals a startling ignorance of general medicine, as it is generally known that sudden death is the commonest presenting symptom of cardiovascular disease.

See Zipes D.P., Wellens H.J.J., *Sudden Cardiac Death.* Circulation. 1998:98:2334-2351; available at *http://circ.ahajournals.org/cgi/content/full/98/21/2334.*

At the time of his death, it is true that Mr. Shealy had various medications available to him, according to investigators and found in the autopsy report, including Zyprexa, Alprazolam 2mg, Paxil CR, Nexium Trazadone (for stage 4 sleep), Provigil 200 mg, OxyContin 80 mg (5 tablets every 12 hours)(180 prescribed on 5/12/02), Roxicodone 30 mg (1-6 tabs every 4 hours for breakthrough pain)(150 prescribed on 5/28/03), and Amitriptyline 100mg.

At the time of his death, there were 14 OxyContin remaining in Mr. Shealy's prescription bottle, and another 5 loose nearby laying outside of his prescription bottle, totaling 19 OxyContin tablets, suggesting that Mr. Shealy may have taken 161 tablets of the medication that Dr. McIver had prescribed on May 12th; if Mr. Shealy had taken 20 tablets a day, as he was instructed he could, starting on May 12th (assuming, for the sake of conjecture, that he took only one on May 12th), then he would have taken 161 tabs by May 28th.

If – as the government insisted – the prescribed OxyContin accounted for Mr. Shealy's death on May 29th, then why hadn't OxyContin caused his death on any earlier

day before he died, as Mr. Shealy apparently took the prescribed dosage without any difficulty for the 16 intervening days until he died on May 29th?

REASONS FOR GRANTING THE PETITION

This case presents an issue in which the Fourth Circuit has decided an important federal question in a way that conflicts with this Court's holding in *United States v. Moore*, 423 U.S. 122, 143, 96 S. Ct. 335 (1975). *See* Rule 10 of the Rules of the Supreme Court of the United States.

A physician who treats chronic pain patients may not be convicted of intending to traffick in drugs for merely failing to conform with a "professional norm" that is "within" but not "outside" the "course of professional medical practice" as is required by this Court's holding in *Moore.*

In the 1970's, this Court wrestled with the question of whether the Controlled Substances Act ("CSA") applied to physicians at all. Congress had enacted legislation that a medical practitioner may "distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance *in the course of professional practice* or research" (emphasis supplied). *See* 21 U.S.C. Section 802(21). This Court therefore held that a physician is criminally liable under Title 21, United States Code, section 841 of the Controlled Substances Act ("CSA") when he is acting, prescribing or distributing, "outside the course of professional practice", meaning as a "drug pusher" instead of as a physician. *United States v. Moore*, 423 U.S. 122, 124, 96 S. Ct. 335 (1975).

This crime requires the physician's specific intent to traffic in drugs. *Id.* The medical practitioner has to act deliberately. *See Morissette v. United States*, 342 U.S. 246,

72 S. Ct. 240 (1952). In *United States v. Rosenberg*, 515 F.2d 190 (9th Cir. 1975), for example, the Court said, "the jury [must] look into [a practitioner's] mind to determine whether he prescribed the pills for what he thought was a medical purpose or whether he was passing out the pills to anyone who asked for them." *Id.*, at 197.

During oral argument, on September 21, 2005, in *United States v. McIver*, Docket No. 05-4884, Circuit Court Judge Wilkinson therefore asked what the government thought the criminal offense was in this case.[1] When the government finally responded, the answer wasn't that Dr. McIver had been trafficking in drugs, it was that he had been "over-prescribing medicine". The government's response at the oral argument conformed to the government's expert opinion, in accordance with his "professional norms", wary of prescribing opioids, falling "within" but not "outside" the bounds of professional practice.

Judge Wilkinson said that he couldn't ignore the fact that the prosecution's expert witness repeatedly testified to "professional norms" and the jury instructions repeatedly referred to violations of "professional norms". Judge Wilkinson expressed concern as to how the expert testimony and the jury instructions interlocked seamlessly around a violation of "professional norms". Judge Wilkinson observed that Congress did not express the critical element of proof for the jury as "a reasonable physician" standard or as "a violation of professional norms." Congress said *'outside* the course of professional practice" (emphasis supplied).

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1. The Circuit's decision upholding the conviction seemed quite at odds with the colloquy had at oral argument. The recording of that argument is available and Petitioner will make same available at the Court's request.

Judge Wilkinson asked the prosecution if what Congress prescribed "wasn't something textually different from a norm of professional practice?" Judge Wilkinson asked, doesn't "outside the course of" mean "you just shuck professional practice to one side" and "set yourself up as a drug dealer" and put all your medical training to one side? Judge Wilkinson asked the prosecution if there wasn't a difference between "professional norms" and "outside the course of professional practice"? The prosecution responded that there was "a difference." And there most certainly was.

No jury instruction was given in Petitioner McIver's case that could cure the deathly combination of the government's expert testimony and the trial court's repeated reference in its jury instructions to "the norms of professional practice." J.A. 1293. The trial court specifically invited the jury, when ascertaining guilt or innocence, to "consider the testimony you have heard relating to what has been characterized during the trial as the norms of professional practice." *Id.* The defense objected in writing to this inapt reference in the instructions. J.A. 1302. Trial counsel suggested curative and clarifying language that was rejected by the Court, and trial counsel explained to the trial court that the instruction wrongly stated "if Dr. McIver violated the medical norms, then he is guilty of the criminal violations." J.A. 1302.

Trial counsel told the court that "[s]imply because a majority or overwhelming majority of physicians believe a procedure or technique wrong, does not mean that it is *outside* the bound of medical practice" (emphasis supplied) J.A. 1303, 1320-1322.

Nor could this error be found harmless by any fair analysis, as the only counts that resulted in conviction were those that were the subject of the government expert's

testimony, who set forth what were "the norms of professional conduct"; the prosecutor himself underscored this fact to the trial court when court and counsel were trying to understand how the jury convicted Dr. McIver as to some patients but not others. J.A. 1326-1327.

Gonzales v. Oregon, 546 U.S. 243, 126 S. Ct. 904 (2006) considered the Attorney General's reach under the Controlled Substances Act and concluded that the Congress had granted the Attorney General a limited role, and authority that did not encompass defining or re-defining the substantive standards of medical practice in administrative guidelines.

What we have here is as egregious as the government's excesses in *Gonzales* in that the Executive Branch, by its Attorney General, is here re-defining the permissible standards of medical practice but not by its administrative guidelines, rather by its expert witness at trial, and by "norms" that are "within" and not "outside" the course of professional medical practice.

When federal prosecutors told a federal district judge that it was their business to determine what constituted "appropriate" medical practices (in connection with assisted suicide), the federal district court denounced their arrogance:

> Federal prosecutors have never possessed such powers, and the vagueness of the [statutory] reference would render any alleged violation based on a prosecutor's subjective views about medical practice patently unenforceable.

Oregon v. Ashcroft, et al, 192 F. Supp. 2d 1077, 1090 (D. Oregon 2002).

Justice Kennedy, writing for a majority of this Court in *Gonzales* said that the Attorney General enjoys no medical expertise, nor authority over medical standards. Id., at 922. Justice Kennedy expressed a prescient concern in *Gonzales* that, if the Attorney General were free to make medical judgments, then those that he "could make [would not be] limited to physician-assisted suicide." *Gonzales v. Oregon*, *supra*, at 921.

According to this Court, "Congress regulates medical practice insofar as it bars doctors from using their prescription-writing powers as a means to engage in illicit drug dealing and trafficking as conventionally understood" but, beyond this, "the statute manifests no intent to regulate the practice of medicine generally." *Gonzales v. Oregon*, *supra*, at 923.

The rationale for the Supreme Court's decision in *Gonzales* was simple: the federal government had to defer to the States' "great latitude under the police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons." *Id.*

No Attorney General may therefore bar a medical use that is at variance or "inconsistent" with another's "reasonable understanding of medical practice." *Gonzales v. Oregon, supra*, at 924.

Thus did the Supreme Court refuse "to effect a radical shift of authority from the States to the Federal Government to define general standards of medical practice in every locality." *Gonzales v. Oregon, supra*, at 925.

Justice Kennedy reaffirmed what the lower court had said, that, if the Attorney General enjoyed this authority to criminalize what it saw fit, then it would enjoy the

"unrestrained" power to criminalize "the conduct of registered physicians whenever they engage in conduct he [the AG] deems illegitimate." *Id.*, at 920.

In this proceeding, the government's expert witness, Mr. Storick, was the government's agent defining in real time, and during the trial, its most recently enunciated standard for the jury, based on the bias of Dr. Storick's settled habits but "within" the "bounds of professional medical practice".

The trial court invited the jury to "consider the extent to which, if at all, *any violation of professional norms you find to have been committed* by the defendant *interfered with his treatment of his patients* and contributed to an *over prescription and/or excessive dispensation* of controlled substances" (underscoring supplied).

These errors as to the proper standard, by expert witness and jury instruction, contravened this Court's holding in *Moore* and fundamental notions of due process.

CONCLUSION

Petitioner respectfully urges this Court to grant the petition for a writ of certiorari.

Respectfully submitted,

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APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT DECIDED DECEMBER 5, 2006

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

No. 05-4884

UNITED STATES OF AMERICA,

Plaintiff-Appellee,

v.

RONALD A. McIVER,

Defendant-Appellant,

and

ALL OUT BAIL BONDING;
GIGGIES BONDING COMPANY,

Parties in Interest.

Argued: September 21, 2006

Decided: December 5, 2006

OPINION

DUNCAN, Circuit Judge:

The field of pain management has generated controversy because of its reliance on opiate-based pain medications (opioids), which are also a target of the government's war on drugs. *See* Diane E. Hoffmann & Anita J. Tarzian,

Appendix A

Achieving the Right Balance in Oversight of Physician Opioid Prescribing for Pain: The Role of State Medical Boards, 31 J.L. Med. & Ethics 21, 22-23 (2003). The government has recently become more aggressive in prosecuting doctors who unlawfully distribute opioids and other prescription drugs under the guise of legitimate medical practice. *See United States v. Hurwitz*, 459 F.3d 463 (4th Cir.2006); *United States v. Feingold*, 454 F.3d 1001 (9th Cir.2006); *United States v. Williams*, 445 F.3d 1302 (11th Cir.2006); *United States v. Alerre*, 430 F.3d 681 (4th Cir.2005). The charges against Dr. Ronald A. McIver ("Appellant") arose from his prescription of pain medications to patients at a pain clinic. He appeals his conviction for various counts of unlawful distribution of a controlled substance, unlawful distribution of a controlled substance resulting in death, and conspiracy to unlawfully distribute a controlled substance. For the reasons that follow, we affirm.

I.

Appellant is a doctor of osteopathic medicine[1] who was licensed to prescribe controlled substances under the Controlled Substances Act, 21 U.S.C. § 801 *et seq.* He

1. "A doctor of osteopathic medicine (D.O.) is a physician licensed to perform surgery and prescribe medication." MedlinePlus Medical Encyclopedia: Doctor of Osteopathy (D.O.), http:// www. nlm. nih. gov/ medlineplus/ency/article/002020.htm. Osteopaths differ from doctors of medicine ("M.D.") in that they receive specialized training in "hands-on manual medicine and the body's musculoskeletal system," and are "dedicated to treating and healing the entire patient as a whole, rather than focusing on one system or body part." *Id.* In practice, however, the roles of D.O.'s and M.D.'s are often identical.

operated a medical clinic in Greenwood, South Carolina that specialized in treating chronic pain. The United States Drug Enforcement Administration ("DEA") began investigating Appellant in 2002 after receiving information about his prescribing practices from the Columbia, South Carolina police department. J.A. 682-83.[2] During its investigation, the DEA discovered that Appellant had prescribed massive quantities of oxycodone,[3] Dilaudid,[4] OxyContin,[5] methadone,[6] and morphine[7] to his patients. J.A. 687-88. The investigation also uncovered a disturbing pattern among Appellant's patients. These patients included admitted drug addicts who traveled significant distances to see him, appeared without referrals, paid in cash,

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2. Our citations to "J.A. ____" refer to the contents of the Joint Appendix filed by the parties in this appeal.

3. Oxycodone is a potent and addictive opioid that is classified as a Schedule II drug under the Controlled Substances Act. *See* 21 U.S.C. § 812 (2000); 21 C.F.R. § 1308.12(b)(1) (2004). It is marketed in instant-release form under trade names such as Roxicodone, Roxicet, OxyIR, and OxyFAST, and in a controlledrelease form as OxyContin.

4. Dilaudid is the trade name for a medication that contains hydromorphone, a potent and addictive opioid that is classified as a Schedule II narcotic. § 1308.12(b)(1).

5. OxyContin is the trade name of a controlled-release form of oxycodone that can be crushed to circumvent the time-release mechanism and then taken either nasally or intravenously.

6. Methadone is a potent and addictive synthetic opioid that is used to treat pain and addiction to other opioids. It is classified as a Schedule II narcotic. § 1308.12(b)(1).

7. Morphine is one of the most powerful and addictive opioids. It is classified as a Schedule II narcotic. § 1308.12(b)(1).

and sought specific drugs which were prescribed for them based on little or no physical examination.

The government indicted Appellant on fifteen counts related to his treatment of ten patients, nine of whom testified for the government at trial. The remaining patient, Larry Shealy, was deceased; his death formed the basis of two counts of the indictment.

After trial, the jury convicted Appellant of one count of conspiracy to distribute controlled substances unlawfully in violation of 21 U.S.C. § 846 (2000) (Count 1), six counts of unlawful distribution of a controlled substance in violation of 21 U.S.C. § 841(a)(1) (2000) (Counts 3-5, 13-15), and two counts of unlawful distribution of a controlled substance resulting in the death of Larry Shealy in violation of § 841(a)(1) & (b)(1)(C) (Counts 11, 12).[8] The district court sentenced Appellant to 240 months on Counts 1, 3, 4, 5, 13, 14, and 15, and 360 months on Counts 11 and 12, to run concurrently. Appellant timely appealed.

We turn now to a consideration of the facts relevant to this appeal, beginning with those involving the six patients whose experiences underlie Appellant's convictions. In the context of Appellant's challenges to the sufficiency of the evidence, we recite those facts in the light most favorable to the government. *United States v. Rahman*, 83 F.3d 89, 93 (4th Cir.1996). We then discuss the testimony of the government's expert witness, Dr. Steven Storick, and the district court's jury instruction on the § 841(a)(1) charges.

8. McIver was acquitted of all charges relating to four patients, identified as "A," "E," "F," and "G" in the indictment. J.A. 15-20.

Appendix A

A. Larry Shealy

Larry Shealy sought treatment from Appellant for back and knee pain. J.A. 416. Appellant treated Shealy almost exclusively with large quantities of various simultaneous combinations of morphine, Oxycontin, oxycodone, and methadone. J.A. 526. Shealy's son, who accompanied his father to many of his appointments, only observed his father receive non-drug therapy once. J.A. 416-17.

Shealy's son testified that after Shealy started seeing Appellant, his father's demeanor changed dramatically. J.A. 417-19. In addition to losing his appetite and weight, Shealy became somnolent and irritable. J.A. 418. On one occasion, Shealy backed his truck into a tree, apparently without realizing he had done so. J.A. 417-18. These changes so worried Shealy's son that he counseled his father to stop seeing Appellant. J.A. 419. Shealy, however, continued seeing Appellant until he died from an oxycodone overdose. J.A. 419-20, 427-30, 456. The level of drugs in Shealy's system when he died was consistent with the amounts Appellant prescribed. J.A. 427-30.

A representative of the company that provided Shealy health insurance testified that the amount and cost of the drugs prescribed to Shealy, along with the frequency of dosage, "was as high as [he had] ever seen." J.A. 134-35. The representative became so concerned about Shealy's prescriptions that he contacted the DEA. J.A. 134.

Appendix A

B. Barbee Brown

Barbee Brown sought treatment from Appellant primarily for reflex sympathetic dystrophy, a chronic neurological condition that causes severe pain. J.A. 518-19. Appellant knew from the outset that Brown had a history of prescription drug and cocaine abuse. J.A. 207-08, 519. He nevertheless prescribed OxyContin, oxycodone, and, later, methadone in various simultaneous combinations for her. J.A. 518-23. Appellant also allowed Brown to manage her own dosing without specifying a maximum amount. J.A. 208. Brown's father wrote to Appellant to express concern about his daughter's treatment, stating that, since coming to see Appellant, Brown had been in a "drug state," "unstable in her speech and ha[d] threatened to kill" her father. J.A. 233, 520. Appellant continued prescribing opioids to Brown, however, maintaining that, if anything, her dose was too low. J.A. 521.

Appellant stopped treating Brown abruptly after less than two months when her insurance stopped covering his care. J.A. 211. He took no steps to wean her from the opioids, however, and she was hospitalized for four days with severe drug withdrawal symptoms. J.A. 211-12.

C. Leslie Smith

Leslie Smith sought treatment from Appellant specifically to obtain prescription painkillers. J.A. 176. Smith traveled sixty miles each way to see Appellant after learning that he had readily prescribed drugs to one of Smith's friends. J.A. 175-76. Smith testified that he lied to Appellant about

pain in his wrist, but that Appellant prescribed high doses of OxyContin and Dilaudid, the drugs that Smith requested, without ordering x-rays. J.A. 178, 180-183. At trial, Smith admitted that he was a drug addict and injected these drugs to satisfy his habit. J.A. 176. Evidence indicates that Appellant was aware of Smith's drug use; Appellant discovered a syringe in Smith's possession during a visit, but on being told that Smith used it for fishing, continued to prescribe Smith's drugs. J.A. 185.

Appellant eventually became sufficiently suspicious that Smith was either using or selling his medications to write to the South Carolina Department of Health and Environmental Control to express those concerns. J.A. 180-81, 684. Appellant, however, continued prescribing drugs to Smith after writing the letter. J.A. 181-82.

D. Seth Boyer

Like Smith, Seth Boyer learned of Appellant from friends and began traveling more than an hour to see him specifically to obtain prescription drugs. J.A. 248, 250-51. Boyer came to his first appointment with Appellant with track marks on his arms from intravenous drug use. J.A. 250-51, 253. Boyer complained of pain in his foot, but, as with Smith, Appellant did not x-ray it before prescribing OxyContin, OxyFast, and Dilaudid. J.A. 249-50, 253. Boyer both used and sold these drugs. J.A. 253. On one occasion, Boyer lied to Appellant about spilling a bottle of liquid oxycodone, and Appellant refilled the prescription immediately. J.A. 255.

Appendix A

E. Kyle Barnes

Kyle Barnes started seeing Appellant for treatment of fibromyalgia, a chronic condition characterized by widespread pain and stiffness, after her former provider was closed by the government because of its prescribing practices. J.A. 347. When Appellant first began treating her, Barnes was addicted to oxycodone. J.A. 346. Even though Barnes was poor and receiving Medicaid, she traveled nearly three hours to see Appellant, paid for his services in cash and filled prescriptions for thousands of dollars worth of medications. J.A. 350, 353, 359, 530.

Appellant prescribed Barnes massive doses of methadone, OxyContin, oxycodone and morphine in various simultaneous combinations. J.A. 354, 356, 529. In one year, Appellant prescribed Barnes 20,562 individual doses of various medications. J.A. 687. Appellant continued to prescribe methadone even after Barnes told him that she could not take it because of side effects. J.A. 354, 356. Barnes sold both the methadone and morphine. J.A. 356, 359.

Evidence supports an inference that Appellant knew Barnes was not taking her medicine as prescribed. At one point after Appellant had prescribed Barnes high doses of opioids for a number of months, she reported running out of her medications. J.A. 530-31. She did not, however, report any of the withdrawal symptoms commonly associated with a sudden cessation of such high doses. J.A. 530-31.

Appendix A

F. Angela Knight

Angela Knight sought treatment from Appellant for chronic back pain after her previous pain clinic was shut down for its prescribing practices. J.A. 388-89. Even though she lived closer to other pain clinics, Knight traveled nearly two-and-one-half hours to see Appellant. J.A. 392, 542. He treated Knight with high doses of OxyContin, along with methadone and oxycodone. J.A. 538-40.

As with other of Appellant's patients, evidence suggested that Knight was not taking her medicine as prescribed. For example, at her former pain clinic, Knight twice tested negative for opioids despite being prescribed OxyContin at the time. J.A. 537-38. Even though her medical records revealed this fact, on her first visit to him, Appellant doubled the dosage of her previous OxyContin prescription. J.A. 390. Thereafter, Appellant continued to prescribe high and escalating doses of opioids for Knight after his office conducted two similar drug tests that detected no opioids in her system. J.A. 538, 542.

On other occasions, Knight tested positive for opioids, indicating that she was, in fact, taking her medications. J.A. 539-40. Knight eventually became addicted to the medications that Appellant prescribed and suffered significant withdrawal when she stopped taking them. J.A. 397.

Appendix A

G. Dr. Steven Storick's Testimony

At trial, the government offered testimony from Dr. Steven Storick ("Dr.Storick"), an anesthesiologist qualified as an expert in pain management. Based on his review of certain patient records, Dr. Storick concluded that the treatment of several of Appellant's patients fell outside the parameters of legitimate medical practice.

With respect to Shealy, for example, Dr. Storick testified that there was "no legitimate reason to be prescribing" combinations of opioids in such high doses based on the patient's medical conditions. J.A. 527. Similarly, given Brown's history of drug abuse, Storick testified that Appellant's treatment went "outside the course of legitimate medical practice," and was "like pouring gasoline onto a fire." J.A. 523.

As to Barnes, Dr. Storick stated that it was uncommon to treat fibromyalgia with the amount and type of medication Appellant prescribed. J.A. 533. Indeed, he testified that Appellant's treatment of her "was one of the worst cases [he had] seen" and that "it was way outside the course of legitimate medical treatment." J.A. 534. In response to questions about Ms. Knight, Dr. Storick testified that it was outside the legitimate practice of medicine for Appellant to prescribe high doses of opioids given her history of negative drug screens. J.A. 542-43.

Dr. Storick was subjected to rigorous cross-examination regarding varying theories of pain management, and acknowledged differences in points of view as to appropriate

levels of pain medication. J.A. 576-80. He was also challenged as to, and defended his opinions regarding, Appellant's treatment of specific patients.

H. Jury Instructions for § 841(a)(1) Charges

Under § 841(a)(1), the government must prove (1) that Appellant knowingly or intentionally distributed a controlled substance; (2) with knowledge that it was controlled under the law; and (3) that he did so "outside the usual course of professional practice." *United States v. Moore*, 423 U.S. 122, 124, 96 S.Ct. 335, 46 L.Ed.2d 333 (1975); *see also United States v. Tran Trong Cuong*, 18 F.3d 1132, 1137 (4th Cir.1994) (setting out elements of § 841(a)(1) charge). With respect to the third element-the only one challenged by Appellant on appeal-the district court instructed the jury extensively prior to its deliberations.[9]

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9. The court instructed the jury in relevant part as follows:

> There are no specific guidelines concerning what is required to support a conclusion that a defendant physician acted outside the usual course of professional practice and for other than a legitimate medical purpose. In making a medical judgment concerning the right treatment for an individual patient, physicians have discretion to choose among a wide range of options. Therefore, in determining whether a defendant acted without a legitimate medical purpose, you should examine all of a defendant's actions and the circumstances surrounding the same.
>
> If a doctor dispenses a drug in good faith, in medically treating a patient, then the doctor has

(Cont'd)

Appendix A

(Cont'd)

dispensed that drug for a legitimate medical purpose in the usual course of medical practice. That is, he has dispensed the drug lawfully.

Good faith in this context means good intentions, and the honest exercise of professional judgment as to the patient's needs. It means that the defendant acted in accordance with what he reasonably believed to be proper medical practice. If you find that a defendant acted in good faith in dispensing the drugs charged in this indictment, then you must find that defendant not guilty.

For you to find that the government has proven this essential element, you must determine that the government has proven beyond a reasonable doubt that the defendant was acting outside the bounds of professional medical practice, as his authority to prescribe controlled substances was being used not for treatment of a patient, but for the purpose of assisting another in the maintenance of a drug habit or dispensing controlled substances for other than a legitimate medical purpose, in other words, the personal profit of the physician.

Put another way, the government must prove as to each count beyond a reasonable doubt that the defendant dispensed the specific controlled substance other than for a legitimate medical purpose and not with the bounds of professional medical practice.

A physician's own methods do not themselves establish what constitutes medical practice. In determining whether the defendant's conduct was within the bounds of professional practice, you should, subject

(Cont'd)

Appendix A

(Cont'd)

to the instructions I give you concerning the credibility of experts and other witnesses, consider the testimony you have heard relating to what has been characterized during the trial as the norms of professional practice.

You should also consider the extent to which, if at all, any violation of professional norms you find to have been committed by the defendant interfered with his treatment of his patients and contributed to an over prescription and/or excessive dispensation of controlled substances. You should consider the defendant's actions as a whole and the circumstances surrounding them. A physician's conduct may constitute a violation of applicable professional regulations as well as applicable criminal statutes. However, a violation of a professional regulation does not in and of itself establish a violation of the criminal law. As I just indicated, in determining whether or not the defendant is guilty of the crimes with which he is charged, you should consider the totality of his actions and the circumstances surrounding them and the extent and severity of any violations of professional norms you find he committed. . . .

There has been some mention in this case from time to time of the standard of care. During the trial the words medical malpractice may have been used. Those words relate to civil actions. When you go to see a doctor, as a patient, that doctor must treat you in a way so as to meet the standard of care that physicians of similar training would have given you under the same or similar circumstances. And if they fall below that line or what a reasonable physician would have done, then they have not exercised that standard of care, which makes them

(Cont'd)

Appendix A

II.

On appeal, Appellant argues that: (1) the district court's instructions on the § 841(a)(1) charges improperly lowered the government's burden of proof; (2) Dr. Storick's expert testimony constituted inadmissible legal opinions; (3) the district court erred in excluding evidence from Appellant's expert witness, Dr. Thomas Duc; and (4) there was insufficient evidence to support each of his convictions. We consider each argument in turn.

A.

1.

Appellant first argues that by referring to "norms of professional practice" in the jury instructions, the district court improperly allowed the jury to convict on a civil, rather than a criminal, standard of proof. We review the accuracy and adequacy of jury instructions de novo, *United States v. Scott*, 424 F.3d 431, 434 (4th Cir.2005), and will not reverse

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(Cont'd)

> negligent and which subjects themselves to suits for malpractice.
>
> That is not what we're talking about. We're not talking about this physician acting better or worse than other physicians. We're talking about whether or not this physician prescribed a controlled substance outside the bounds of his professional medical practice.

J.A. 1291-96.

a conviction so long as "the instructions, *taken as a whole*, adequately state the controlling law," *United States v. Wills*, 346 F.3d 476, 492 (4th Cir.2003) (emphasis added). Because we find that the district court's instructions as a whole adequately articulated a criminal standard of proof, we find no error.

The potential for juries to confuse the civil standard of care applied in medical malpractice cases and the criminal standard of proof applied in § 841(a)(1) prosecutions requires courts to exercise care in setting out the governing standard in the latter circumstance.[10] We have previously considered the proper relationship between the standards in two decisions that are relevant to our analysis here, even though neither involved a direct challenge to the propriety of § 841(a)(1) jury instructions.

In *Tran Trong Cuong*, we addressed a sufficiency of the evidence challenge by Tran, a physician also indicted under § 841(a)(1). Tran's argument in part was that the district court erroneously applied a civil negligence, rather than a criminal, standard of proof during trial. 18 F.3d at 1137. While acknowledging that the district court had, during trial,

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10. In *Alerre* we pointed out that, "[i]n contrast to the criminal standard, a medical malpractice plaintiff in South Carolina must show in a civil case (1) 'the generally recognized practices and procedures that would be exercised by competent practitioners in a defendant doctor's field of medicine under the same or similar circumstances,' and (2) 'that the defendant doctor departed from the recognized and generally accepted standards, practices, and procedures.' " 430 F.3d at 690 (citing *Gooding v. St. Francis Xavier Hosp.*, 326 S.C. 248, 487 S.E.2d 596, 599 (1997)).

confused the two standards, we nevertheless concluded that the court's articulation of the criminal standard was correct when it instructed the jury at the close of the case. *Id.* at 1137-38. The trial court made it clear in its jury charge that the government must "prove beyond a reasonable doubt . . . that the defendant prescribed the drug other than for [a] legitimate medical purpose and not in the usual course of medical practice." *Id.* at 1137. It then recognized the broad discretion afforded doctors, instructed the jury to consider all of the defendant's actions, and provided specific examples of behavior that tended to denote illegitimacy, such as prescribing drugs without performing physical examinations, or asking patients about the amount or type of drugs they want. *Id.* at 1137-38. We held that these instructions adequately articulated the government's criminal burden of proof, and did not endorse the use of a negligence standard. *Id.* Indeed, we concluded that the jury instructions not only captured the criminal standard, but arguably imposed a higher burden on the government than set forth in *Moore* by additionally requiring proof that Tran had written prescriptions "without a legitimate medical purpose." *Id.*

In *Alerre*, in response to an argument that the entire trial was infected with an erroneous standard of proof, we approved instructions that largely mirrored those in *Tran Trong Cuong* but more fully developed "the distinction between the civil standard and the criminal standard." 430 F.3d at 691 n. 9. The district court in *Alerre* distinguished civil standard-of-care evidence, explained the burden of proof necessary for a criminal conviction, and cautioned the jury that "the critical issue . . . was not whether the defendants had acted negligently, but whether or not [they] prescribed a

controlled substance outside the bounds of their professional medical practice." *Id.* (quotations omitted).

Significantly, we recognized in *Alerre* that merely because standard-of-care evidence might show that a physician contravened the civil standard, it need not be categorically excluded from a criminal proceeding. *Id.* at 691. To the contrary, "evidence that a physician consistently failed to follow generally recognized procedures tends to show that in prescribing drugs he was not acting as a healer but as a seller of wares." *Id.* Similarly, we recognized that evidence that a physician "deviated drastically from accepted medical standards" is probative of criminal liability. *Id.*

With that guidance, we consider the challenge before us, which specifically focuses on the district court's jury instructions. The thrust of Appellant's argument is that the district court erred in telling the jury to consider the extent to which "any violation of professional norms you find to have been committed by the defendant interfered with his treatment of his patients and contributed to an over prescription and/or excessive dispensation of controlled substances." J.A. 1293. Appellant specifically focuses on the district court's use of the phrase "norms of professional practice." However, after reviewing the jury instructions *as a whole*, as we must, *Wills*, 346 F.3d at 492, we find multiple reasons to conclude that the instructions here properly set forth the criminal standard required by § 841(a)(1).

As was the case in *Tran Trong Cuong*, 18 F.3d at 1137, and *Alerre*, 430 F.3d at 687, the court below cabined both its overall § 841(a)(1) instruction, as well as its specific

instructions on the third element, within the requirement of proof "beyond a reasonable doubt." J.A. 1290, 1292. This statement clearly articulated the proper criminal burden for the government and precluded conviction on a lesser civil standard of proof.

The court then properly defined the scope of unlawful conduct under § 841(a)(1) by explaining that the government had to prove that Appellant used "his authority to prescribe controlled substances . . . not for treatment of a patient, but for the purpose of assisting another in the maintenance of a drug habit or" some other illegitimate purposes, such as his own "personal profit." J.A. 1292; *see Alerre*, 430 F.3d at 690-91. This instruction set the proper threshold for conviction by placing unlawful conduct beyond the bounds of any legitimate medical practice, including that which would constitute civil negligence. *See Tran Trong Cuong*, 18 F.3d at 1137; *cf. Alerre*, 430 F.3d at 690 (setting forth the standard for medical malpractice in South Carolina). In other words, the district court ensured that the jury could only convict Appellant for conduct that was exclusively criminal in nature.

Significantly, in order to satisfy this definition of unlawful conduct, the district court required the prosecution to prove, not only that Appellant acted "outside the course of professional practice," as required by *Moore*, 423 U.S. at 124, 96 S.Ct. 335, but also that he acted " *for other than a legitimate medical purpose*," J.A. 1292 (emphasis added). This additional requirement arguably benefitted Appellant by placing an even heavier burden on the government than

otherwise required to establish criminal liability. *See Alerre*, 430 F.3d at 690-91; *Tran Trong Cuong*, 18 F.3d at 1138.

As in *Tran Trong Cuong*, 18 F.3d at 1138, and *Alerre*, 430 F.3d at 691 n. 9, the court next stated that so long as Appellant acted in good faith, he acted lawfully. J.A. 1291-92; *see* 430 F.3d at 692, 18 F.3d at 1138. The significance of this distinction is manifest: good faith is a defense to a charge under § 841(a)(1), but not to a claim of medical malpractice. *See Hurwitz*, 459 F.3d at 480 ("good faith generally is relevant in a § 841 case against a registered physician"); *Pleasants v. Alliance Corp.*, 209 W.Va. 39, 49 n. 27, 543 S.E.2d 320 (2000) (collecting cases rejecting use of subjective good faith jury instructions in medical malpractice actions). The inclusion of a good faith instruction is therefore a plainspoken method of explaining to the jury a critical difference between the two standards.

Finally, the court instructed the jury on the difference between civil and criminal violations. J.A. 1293. The court indicated that "a violation of a professional norm does not in and of itself establish a violation of [a] criminal law," but could support a conviction based on its "extent and severity." *Id.* While this instruction allowed the jury to consider civil violations, it properly explained that such evidence is not inexorably indicative of unlawfulness. *See Alerre*, 430 F.3d at 691. The district court then concluded by describing the concept of medical malpractice and the civil standard of care before categorically stating that a criminal standard governed resolution of this case.[11] J.A. 1293-96 ("[Malpractice or

11. While not directly relevant to the distinction between a civil and criminal standard of proof, we further note that the court here (Cont'd)

negligence] is not what we're talking about .... We're talking about whether or not this physician prescribed a controlled substance outside the bounds of his professional medical practice.").

These instructions, taken as a whole, set the proper threshold for conviction, mandating application of a criminal standard of proof and precluding conviction on a lower civil standard. The fact that the district court may have invoked language, taken in isolation, suggestive of a civil standard, would not alone lower the government's burden of proof. Indeed, it would be difficult, if not impossible, to purge an instruction under § 841(a)(1) of all references to permissible standards or norms of care, since the third element of § 841(a)(1) requires a determination of whether the defendant's conduct is outside the usual course of professional conduct.

The jury instructions here went further in defining the proper criminal standard and distinguishing it from the civil standard than those which we approved, albeit in different contexts, in both *Tran Trong Cuong* and *Alerre*. We therefore find no error with the district court's instructions.

(Cont'd)

mirrored the instructions in both *Tran Trong Cuong*, 18 F.3d at 1137-38, and *Alerre*, 430 F.3d at 691 n. 9, by instructing the jury to base its decision on all of Appellant's actions and the surrounding circumstances. J.A. 1291. Appellant thus received the benefit of court-sanctioned deference to his professional judgment.

2.

Appellant further argues that Dr. Storick's testimony combined with the instructions on the third element to lower the government's burden. At trial, Dr. Storick opined that Appellant acted "outside the course of legitimate medical practice," "inappropriate[ly]" or "with no legitimate reason." J.A. 523, 527, 543. Appellant argues that the confluence of this testimony and the court's instructions regarding the "norms of professional practice" effectively allowed the jury to convict based on a civil standard of proof. We find this argument unpersuasive for two reasons.

First, as we recognized in *Alerre* and noted above, evidence regarding a departure from a generally recognized standard-of-care is not inherently impermissible. 430 F.3d at 691. To the contrary, such evidence may support an inference that a physician is acting as a dealer of drugs rather than a provider of care.[12] *Id.* Indeed, it is the extent and severity of departures from the professional norms that underpin a jury's finding of criminal violations. *See id.* ("[E]vidence that a physician consistently failed to follow generally recognized procedures tends to show that in prescribing drugs he was not acting as a healer but as a seller of wares.")

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12. We entrust to the district court the task of ensuring that such evidence is sufficiently constrained as to not confuse a jury. *See* Fed.R.Evid. 403 (requiring exclusion of confusing evidence); *Alerre*, 430 F.3d at 691 n. 10 (noting that "undue emphasis on standard-of-care evidence might, in certain circumstances, confuse a jury."). Based on the record before us, we find nothing improper with the evidence admitted at trial.

Second, even if we assume that Dr. Storick suggested a lower burden to the jury, the district court's jury charge negated any such testimony by articulating the proper standard. Again, our decision in *Tran Trong Cuong* is instructive. The district court there made statements at trial that unambiguously indicated that a civil standard of proof governed the case, commenting, for example, that the governing standard was (1) "whether a reasonably prudent physician would do it," (2) "whether it is within the standard of care of a family practitioner," and (3), "like you use in a civil case, whether [care was comparable to that provided] in the usual course of treating a patient by the average family practitioner." 18 F.3d at 1137. We concluded, nonetheless, that the satisfactory definition included in the jury instructions cured the prior misstatements. *Id.* at 1138. Such a conclusion is consistent with our general presumption that "a properly instructed jury [acts] in a manner consistent with the instructions." *Alerre*, 430 F.3d at 692; *see Jones v. United States*, 527 U.S. 373, 394, 119 S.Ct. 2090, 144 L.Ed.2d 370 (1999) ("[J]urors are presumed to have followed . . . instructions.").

As discussed above, the district court here instructed the jury that the government had to satisfy a criminal standard of proof to convict Appellant. J.A. 1291-96. We presume that the jury followed these instructions and ignored any suggestion to the contrary. *See Jones*, 527 U.S. at 394, 119 S.Ct. 2090; *Alerre*, 430 F.3d at 692. We discern nothing in the record that rebuts this presumption. Accordingly, we find no error.

Appendix A

B.

Appellant next asserts error in the admission of Dr. Storick's expert testimony that Appellant treated certain patients outside the course of legitimate medical practice. Appellant argues that this testimony embraced inadmissible legal conclusions. We review this argument for plain error because Appellant did not object to the testimony at trial. *United States v. Ellis*, 121 F.3d 908, 918 (4th Cir.1997). To reverse on plain error review, we "must '(1) identify an error, (2) which is plain, (3) which affects substantial rights, and (4) which seriously affect[s] the fairness, integrity or public reputation of judicial proceedings.' " *Id.* (quoting *United States v. Brewer*, 1 F.3d 1430, 1434 (4th Cir.1993)) (alterations in original). Because we conclude that Dr. Storick's testimony was admissible, there was no error and Appellant cannot satisfy this standard.

Rule 704(a) allows the admission of expert testimony that "embraces an ultimate issue to be decided by the trier of fact." Fed.R.Evid. 704(a). In other words, questions of fact that are committed to resolution by the jury are the proper subject of opinion testimony. *Id.* However, opinion testimony that states a legal standard or draws a legal conclusion by applying law to the facts is generally inadmissible.[13]

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13. We have previously recognized that in certain circumstances, such as cases involving specialized industries, "opinion testimony that arguably states a legal conclusion is helpful to the jury, and thus, admissible." *United States v. Barile*, 286 F.3d 749, 760 n.7 (4th Cir.2002) (quoting Weinstein's Federal Evidence § 704.04[2][a] (2d ed.2001)). Because we conclude that Dr. Storick's

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See United States v. Barile, 286 F.3d 749, 760 (4th Cir.2002); *Okland Oil Co. v. Conoco, Inc.*, 144 F.3d 1308, 1328 (10th Cir.1998). The line between a permissible opinion on an ultimate issue and an impermissible legal conclusion is not always easy to discern. *Barile*, 286 F.3d at 760. We identify improper legal conclusions by determining whether "the terms used by the witness have a separate, distinct and specialized meaning in the law different from that present in the vernacular." *Id.* For example, courts have held inadmissible testimony that a defendant's actions constituted "extortion," *DiBella v. Hopkins*, 403 F.3d 102, 121 (2d Cir.2005); that a dog bite constituted "deadly force," *Miller v. Clark County*, 340 F.3d 959, 963 n. 7 (9th Cir.2003); that defendants held a "fiduciary" relationship to plaintiffs, *Christiansen v. Nat'l Sav. & Trust Co.*, 683 F.2d 520, 529 (D.C.Cir.1982); and that a product was "unreasonably dangerous," *Strong v. E.I. DuPont de Nemours Co.*, 667 F.2d 682, 685-86 (8th Cir.1981). Dr. Storick's testimony, however, does not involve terms with similar legal significance.

On the issue of whether Appellant acted "outside the bounds of his professional medical practice and for other than legitimate medical purposes," *Tran Trong Cuong*, 18 F.3d at 1137,[14] Dr. Storick opined that Appellant's treatment

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(Cont'd)

testimony did not embrace improper legal conclusions, we need not confront the question of whether his testimony falls under this exception.

14. This issue is a question of fact that is entrusted to the jury, *see Tran Trong Cuong*, 18 F.3d at 1137-38 (approving instructions

(Cont'd)

of certain patients was either illegitimate or inappropriate. J.A. 523, 527, 534, 541, 557-58. Although Dr. Storick used terms similar to that which this court has employed to express the underlying issue, none is sufficiently specialized to render his testimony inadmissible. Rather, the language Dr. Storick employed falls within the limited vernacular that is available to express whether a doctor acted outside the bounds of his professional practice.[15] We conclude therefore that the district court properly admitted Dr. Storick's testimony and that Appellant cannot establish plain error.

C.

Appellant argues that the district court erred by excluding testimony from his expert witness, Dr. Thomas Duc. During direct examination, Appellant's attorney asked Dr. Duc whether a minority group of doctors who treat pain aggressively with opioids acted "within the bounds of medical practice." J.A. 1085. The government raised an objection to this testimony, which the district court sustained,

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(Cont'd)

given to jury on this issue); *United States v. Kaplan*, 895 F.2d 618, 623-24 (9th Cir.1990) (treating issue as question for jury); *Oregon v. Ashcroft*, 192 F.Supp.2d 1077, 1090 n. 15 (D.Or.2002) (recognizing issue as a question of fact for jury), and, therefore, is the proper subject of expert testimony, *see* Fed.R.Evid. 704(a).

15. We note as well that experts in *Tran Trong Cuong* and *Alerre* testified similarly, and that the defendant in *Tran Trong Cuong* relied on the opinions of two physicians that his prescription practices were "within the state of the art" or "the medical standard." 430 F.3d at 686, 18 F.3d at 1135.

on the grounds that it called for a legal conclusion. *Id.* Even if the district court's exclusion of this testimony were improper, any such error was harmless because of the examination that followed. *See United States v. Pendergraph*, 388 F.3d 109, 112 (4th Cir.2004) (recognizing that error in exclusion of evidence is harmless if it does not substantially sway the judgment).

After the district court sustained the government's objection, Appellant's attorney reworded his inquiry and conducted, without objection, a thorough examination of Dr. Duc's opinions on various approaches to pain management. J.A. 1085-88. This testimony was substantively identical to that sought from the initial question; it was merely elicited through an unobjectionable, if somewhat more cumbersome, line of questioning. Because of the similarity between the two lines of inquiry, we conclude that any error in the exclusion of the initial line of questioning did not sway the jury and, therefore, was harmless.

D.

Finally, Appellant argues that there was insufficient evidence to support each of his convictions. A "jury's verdict must be upheld on appeal if there is substantial evidence in the record to support it." *United States v. Wilson*, 198 F.3d 467, 470 (4th Cir.1999). In making this determination, "we view the evidence in the light most favorable to the government and inquire whether there is evidence that a 'reasonable finder of fact could accept as adequate and sufficient to support a conclusion of a defendant's guilt beyond a reasonable doubt.' " *Id.* (quoting *United States v.*

Burgos, 94 F.3d 849, 862 (4th Cir.1996) (en banc)). We now turn to an analysis of each claim.

1. Count 1, Conspiracy to Unlawfully Distribute a Controlled Substance

Appellant argues that the government did not present sufficient evidence on Count 1 to prove either that he entered into an illicit agreement with his patients to distribute controlled substances unlawfully or that he did so knowingly. Proof of each was a necessary element of the conspiracy charge against him. *United States v. Cropp*, 127 F.3d 354, 361 (4th Cir.1997); *United States v. Clark*, 928 F.2d 639, 641-42 (4th Cir.1991). There is ample evidence, however, to support each element.

With respect to the first element, "it is not necessary to prove a formal agreement to establish a conspiracy in violation of federal law; a tacit or mutual understanding among or between the parties will suffice." *United States v. Depew*, 932 F.2d 324, 326 (4th Cir.1991). There was evidence that many of Appellant's patients were drug addicts who sought treatment from him with the express purpose of obtaining drugs and, further, that he prescribed drugs in quantities greater than he had reason to believe, or that tests revealed, his patients were using. *See* J.A. 134-35, 176, 248, 354, 356, 523, 527, 529, 533-34, 538-40, 543, 687. Viewed in a light most favorable to the government, this evidence supports a conclusion that McIver tacitly agreed with his patients to provide opioid prescriptions without legitimate medical reasons for doing so.

Appendix A

The government can satisfy the knowledge requirement by showing either that Appellant actually knew of the conspiracy, *Cropp*, 127 F.3d at 361, or that he was willfully blind to it by "purposely clos[ing] his eyes to avoid knowing what was taking place around him." *United States v. Ruhe*, 191 F.3d 376, 384 (4th Cir.1999) (quoting *United States v. Schnabel*, 939 F.2d 197, 203 (4th Cir.1991)). The government presented a plethora of evidence that demonstrates that Appellant either knew of the conspiracy, or, at the very least, was willfully blind to the unlawfulness of his actions.

Testimony showed that Appellant consistently prescribed large quantities of opioids despite warning signs that his patients were not using their medications as prescribed, were seeking his treatment specifically to obtain drugs, or were drug addicts. *See* J.A. 177-78, 180-82, 185, 207-08, 233, 250-51, 253, 350, 353, 359, 390, 392, 518-23, 530-31, 538, 542. Indeed, Appellant continued prescribing medication to one patient after she repeatedly told him that she could not take it, J.A. 356; to another after developing sufficient concern that the patient was selling his medication to contact state officials, J.A. 180-81; and to yet another after finding a syringe in his possession, J.A. 185. Evidence also revealed instances in which Appellant failed to conduct even the most basic diagnostic testing before prescribing opioids. *See* J.A. 184, 249. Taken together, this evidence supports either of two alternate conclusions: that Appellant had actual knowledge that he was prescribing drugs for non-medical purposes or that he was willfully blind to his patient's true motives in seeking his care. Either circumstance establishes Appellant's knowledge of the conspiracy.

On this record, we conclude that the government presented sufficient evidence to satisfy both the agreement and knowledge elements of the conspiracy charge.

2. Counts 3-5 & 13-15, Unlawful Distribution of a Controlled Substance

Appellant challenges the sufficiency of the evidence on the third element of the § 841(a)(1) charges, whether he prescribed substances "outside the usual course of professional practice." [16] *See Alerre*, 430 F.3d at 690 (quoting *Moore*, 423 U.S. at 124, 96 S.Ct. 335).

However, the evidence demonstrated that McIver freely distributed prescriptions for large amounts of controlled substances that are highly addictive, difficult to obtain, and sought after for nonmedical purposes. J.A. 134-35, 176, 180-83, 248, 251, 253, 255, 346, 354-56, 388-90, 518-23, 526, 529, 538-40. For one patient, he prescribed more than 20,000 pills in a single year. J.A. 687. He prescribed drugs to patients that he either knew or had reason to believe would not take them as directed. J.A. 354, 356. Some of his patients were drug addicts who sought treatment from him specifically to obtain controlled substances to use or to sell. J.A. 176, 248, 251, 253, 346, 356, 359. That Appellant knew or suspected his patients of drug abuse is reflected by the fact that he wrote to state authorities to express concern that his patients might be selling their medications. J.A. 126, 180-81. Appellant exercised minimal medical oversight of his patients' dosing practices. J.A. 184, 208, 249, 351, 416-17. He ignored

16. Appellant does not contest the evidence as to either of the first two elements.

evidence of the danger of prescribing drugs to certain patients, the drug-seeking behavior of others, and the drug abuse of still others. J.A. 177-78, 180-82, 185, 207-08, 233, 250-51, 253, 350, 353, 359, 390, 392, 518-23, 530-31, 538, 542. After several of Appellant's patients stopped seeing him, they suffered significant drug withdrawal effects, at least in one instance requiring hospitalization. J.A. 211-12, 397. Dr. Storick testified at length about the extent to which Appellant's procedures went beyond the parameters of legitimate medical practice. J.A. 523, 527, 533, 542-43.

This evidence amply supports a finding that McIver's actions went beyond the legitimate practice of medicine and were "no different than [those of] a large-scale pusher, *Tran Trong Cuong*, 18 F.3d at 1138, and is thus sufficient to support each of McIver's § 841(a)(1) convictions.

3. Counts 11 & 12, Unlawful Distribution of a Controlled Substance Resulting in Death

In order to prove Counts 11 and 12, the government had to establish that McIver unlawfully distributed drugs to Shealy that resulted in his death. § 841(b)(1)(C). McIver argues only that the government did not present sufficient evidence to demonstrate that Shealy died from the drugs that he prescribed. Again, we disagree.

Both the pathologist who conducted Shealy's autopsy and the forensic toxicologist who examined his bodily fluids testified that Shealy died as a result of an oxycodone overdose. J.A. 419-20, 427-30, 456. The pathologist further testified that the amount of oxycodone in his system at the

time of death was consistent with the amount prescribed by McIver. J.A. 427-30. This testimony is sufficient to support McIver's conviction on Counts 11 and 12.

III.

In light of the foregoing, each of McIver's convictions is

AFFIRMED.

APPENDIX B — JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF SOUTH CAROLINA DATED SEPTEMBER 14, 2005

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA

UNITED STATES OF AMERICA

vs.

RONALD MCIVER

JUDGMENT IN A CRIMINAL CASE
(For Offenses Committed On or After November 1, 1987)

Case Number: *8:04-745 (1)*
US Marshal's Number: *11764-171*

C. Rauch Wise
Defendant's Attorney

THE DEFENDANT:

* * *

■ was found guilty on count(s) *1, 3, 4, 5, 11, 12, 13, 14 and 15* on *April 19, 2005* after a plea of not guilty. Accordingly, the court has adjudicated that the defendant is guilty of the following offense:

Title & Section	Nature of Offense	Date Offense Concluded	Count Number
21:846, 21:841(a)(1), 841(b)(1)(C)	Please see indictment	4/04	1
21:841(a)(1), 18:2	Please see indictment	3/21/02	3
21:841(a)(1), 18:2	Please see indictment	4/16/02	4
21:841(a)(1), 18:2	Please see indictment	4/19/02	5
21:841(a)(1), 18:2	Please see indictment	5/29/03, 5/12/03	11
21:841(a)(1), 18:2	Please see indictment	5/29/03, 5/28/03	12
21:841(a)(1), 18:2	Please see indictment	5/22/03	13
21:841(a)(1), 18:2	Please see indictment	3/9/04	14
21:841(a)(1), 18:2	Please see indictment	3/11/04	15

Appendix B

The defendant is sentenced as provided in pages 2 through 5 of this judgment. The sentence is imposed pursuant to the Sentencing Reform Act of 1984.

■ The defendant has been found not guilty on count(s) *2, 6, 7, 8, 9 and 10*

* * *

IT IS ORDERED that the defendant shall notify the United States Attorney for this district within 30 days of any change of name, residence, or mailing address until all fines, restitution, costs, and special assessments imposed by this judgment are fully paid. If ordered to pay restitution, the defendant shall notify the court or United States attorney of any material change in the defendant's economic circumstances.

August 26, 2005
Date of Imposition of Judgment

s/ Henry F. Floyd
Signature of Judicial Officer

Henry F. Floyd, United States District Judge
Name and Title of Judicial Officer

September 14, 2005
Date

Appendix B

IMPRISONMENT

The defendant is hereby committed to the custody of the United States Bureau of Prisons to be imprisoned for a total term of *360 months*. This term consists of 20 years (240 months) as to Counts 1, 3, 4, 5, 13, 14 and 15 and 360 months as to Counts 11 and 12, all such terms to run concurrently.

* * *

■ The defendant is remanded to the custody of the United States Marshal.

* * *

SUPERVISED RELEASE

Upon release from imprisonment, the defendant shall be on supervised release for a term of *5 years*. This term consists of 5 years as to counts 1, 3, 4, 5, 11, 12, 13, 14 and 15, all such terms to run concurrently.

1) The defendant shall participate in a program for mental health treatment as directed by the probation officer, until such time as the defendant is released from the program by the probation officer.

The defendant shall report to the probation office in the district to which the defendant is released within 72 hours of release from the custody of the Bureau of Prisons.

The defendant shall not commit another federal, state, or local crime.

The defendant shall not illegally possess a controlled substance.

Appendix B

For offenses committed on or after September 13, 1994:

The defendant shall refrain from any unlawful use of a controlled substance. The defendant shall submit to one drug test within 15 days of release from imprisonment and at least two periodic drug tests thereafter.

* * *

■ The defendant shall not possess a firearm, destructive device, or any other dangerous weapon.

* * *

If this judgment imposes a fine or a restitution obligation, it shall be a condition of supervised release that the defendant pay any such fine or restitution that remains unpaid at the commencement of the term of supervised release in accordance with the Schedule of Payments set forth in the Criminal Monetary Penalties sheet of this judgment.

The defendant shall comply with the standard conditions that have been adopted by this court (set forth below). The defendant shall also comply with any additional conditions on the attached page.

STANDARD CONDITIONS OF SUPERVISION

1) the defendant shall not leave the judicial district without the permission of the court or probation officer;
2) the defendant shall report to the probation officer and shall submit a truthful and complete written report within the first five days of each month;
3) the defendant shall answer truthfully all inquiries by the probation officer and follow the instructions of the probation officer;
4) the defendant shall support his or her dependents and meet other family responsibilities;

Appendix B

5) the defendant shall work regularly at a lawful occupation unless excused by the probation officer for schooling, training, or other acceptable reasons;
6) the defendant shall notify the probation officer at least ten days prior to any change in residence or employment;
7) the defendant shall refrain from excessive use of alcohol and shall not purchase, possess, use, distribute, or administer any controlled substance or any paraphernalia related to controlled substances, except as prescribed by a physician;
8) the defendant shall not frequent places where controlled substances are illegally sold, used, distributed, or administered;
9) the defendant shall not associate with any persons engaged in criminal activity, and shall not associate with any person convicted of a felony unless granted permission to do so by the probation officer;
10) the defendant shall permit a probation officer to visit him or her at any time at home or elsewhere and shall permit confiscation of any contraband observed in plain view by the probation officer;
11) the defendant shall notify the probation officer within seventy-two hours of being arrested or questioned by a law enforcement officer;
12) the defendant shall not enter into any agreement to act as an informer or a special agent of a law enforcement agency without the permission of the court;
13) as directed by the probation officer, the defendant shall notify third parties of risks that may be occasioned by the defendant's criminal record or personal history or characteristics, and shall permit the probation officer to make such notifications and to confirm the defendant's compliance with such notification requirement.

Appendix B

CRIMINAL MONETARY PENALTIES

The defendant will make all checks and money orders payable to the **"Clerk, U.S. District Court"** unless otherwise directed by the court.

The defendant shall pay the following total criminal monetary penalties in accordance with the schedule of payments set forth on Sheet 5, Part B.

	Assessment
Totals:	$ 900.00

* * *

If the defendant makes a partial payment, each payee shall receive an approximately proportioned payment unless specified in the priority order or percentage payment column below. However, pursuant to 18 U.S.C. § 3664(8), all nonfederal victims must be paid in full prior to the United States receiving payment.

* * *

Appendix B

SCHEDULE OF PAYMENTS

Having assessed the defendant's ability to pay, payment of the total criminal monetary penalties shall be due as follows:

A ■ Lump sum payment of *$ 900.00 special assessment* due immediately.

* * *

Unless the court has expressly ordered otherwise in the special instructions above, if this judgment imposes a period of imprisonment, payment of criminal monetary penalties shall be due during the period of imprisonment. All criminal monetary penalties, except those payments made through the Federal Bureau of Prisons' Inmate Financial Responsibility Program, are made to the clerk of court, unless otherwise directed by the court, the probation officer, or the United States attorney.

The Defendant shall receive credit for all payments previously made toward any criminal monetary penalties imposed.

* * *

Payments shall be applied in the following order: (1) assessment, (2) restitution principal, (3) restitution interest, (4) fine principal, (5) community restitution, (6) fine interest, (7) penalties, and (8) costs, including cost of prosecution and court costs.

APPENDIX C — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT DENYING PETITION FOR REHEARING FILED JANUARY 3, 2007

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

No. 05-4884
CR-04-745

UNITED STATES OF AMERICA

Plaintiff - Appellee

v.

RONALD A. MCIVER

Defendant - Appellant

and

ALL OUT BAIL BONDING;
GIGGIES BONDING COMPANY

Parties in Interest

On Petition for Rehearing En Banc

The appellant's petition for rehearing en banc was submitted to this Court. As no member of this Court requested a poll on the petition for rehearing en banc,

Appendix C

IT IS ORDERED that the petition for rehearing en banc is denied.

Entered for a panel composed of Judge Wilkinson, Judge Duncan, and Judge Voorhees.

For the Court

/s/ Patricia S. Connor
CLERK